one has broken down mentally as well as physically and nine are pursuing their profession. One is head nurse in a small sanatorium and receives $60 per month; four others have institutional positions; three are engaged in private practice and one, a recent graduate, is resting at home before accepting cases.

It is distinctly understood that these women are trained to nurse tuberculous patients only and the prevalence of this wide-spread disease assures them occupation in this restricted medical field. Last year the undergraduates alone earned $582 for the institution. The number of women trained and prepared for a suitable vocation in this training school amounts only to the proverbial "drop in the bucket," but the results already achieved are gratifying to those who have had a part in the undertaking and commend the movement to the larger sanatoria where larger classes are necessary.

OBSTETRICAL NURSING[1]

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One of our noted men in the obstetrical world has said that it is doubtful if in all the realm of medicine and nursing there is a class of patients which has suffered so much neglect and abuse as that of the lying-in women and the new-born. When a woman has proved her incapacity for continuous sustained work in any other direction or has, apparently, out-lived her usefulness in every other capacity, she can yet do confinement nursing for eight or twelve dollars a week. She has been present at a few confinements, where a practitioner of a previous generation has officiated, and his methods and results are, to her, the only ones worth knowing. Time goes on and art and science advance, but if a man convertible to new ideas after forty is a rarity, what is a woman? Ignorant, weak or lazy, hide-bound by antiquated medical opinions and midwives' and old grannies' wisdom, she presents a veritable Chinese inertia to any attempt at bringing modern science into the lying-in room. She will frighten the patient by the terrible danger to life into lying flat upon her back and will cause many an hour of mental anguish by wise diagnosis of tongue-tie or retention of urine.

The obstetrical nurse has a great field before her, one which should prove to be one of the most satisfactory of the nursing profession.

[1] Read at the third annual meeting of the North Dakota State Nurses' Association, Grand Forks, April 27, 28.

There is in this work ample room for the exercise of both talent and virtue and the nurse who possesses conscience, courage and tact, certainly may do much toward lessening the dangers which have heretofore fallen upon the puerperal women.

The duties of the nurse are manifold, but the first and foremost one is that of preventing infection by always exercising the greatest aseptic precautions in regard to the patient. By being quick to observe any danger signals which may give warning of coming complications and reporting the same, the nurse may be of the greatest service not only to her patient but the doctor as well.

After the completion of the third stage of labor, the patient will often be found to have chills which, however, are not followed by any rise of temperature. After the vulvar toilet has been made, the abdominal binder applied, and the patient made comfortable, she will sleep if not too nervous. The nurse must then remain watchful; she must know that the flow of blood from the uterus is not excessive and that the patient's sleep is a restful one and not a dangerous unconsciousness caused by internal bleeding.

During the first few days after delivery the lochia is bloody and quite profuse in some women; about the third, fourth or fifth day it begins to assume a brownish color which each day gradually becomes lighter; near the tenth day it is pink or yellowish. The amount gradually decreases. The lochia has a certain characteristic odor which can hardly be mistaken and it is important that the nurse know how to tell the difference between the characteristic and the foul odor. If foul, the doctor must be told of it, as it may be a symptom of complication.

The temperature usually remains normal but, if above normal, the cause may be found in the distention of the breasts by milk, in neglect of proper attention to the bowels, discomfort due to retention of urine, or worry. If it rises above 100, especially on the third or fourth days and if followed or preceded by chills, however slight they may be, infection may be feared and the doctor should at once be notified. If the pulse should rise suddenly above a hundred, in a case where no exertion or mental excitement has taken place, the nurse need be on the lookout for other symptoms, as this may be a forerunner of other complications.

During the first few days after delivery the patient is nearly always constipated and it is necessary to produce evacuation of the bowels by the use of enemata and mild cathartics. The patient often has difficulty in urinating the first time after labor. In this case the nurse may try the various ways of inducing micturition; if necessary to

catheterize, the utmost aseptic precautions should be exercised. There is a marked decrease in the amount of urine voided the first few days after labor.

The secretion from the breast is first colostrum and is usually small in amount; on the second and third day it becomes more yellow and soon changes into milk. The breasts are soft to the touch up to the second or third day when some women complain of soreness in them and they are hard and tense. If this condition does not subside soon, the nurse will treat them according to the doctor's orders. Should massage be ordered, it must be given gently in order not to damage the delicate tissue of the gland. The strokes should be directed away from the nipple, as the object is to encourage the flow of blood away from the breast. If left to her own responsibility, the nurse will apply a moderately tight binder which often relieves this condition. After this the breasts assume more fulness but are soft and do not cause any trouble unless over-distended by milk, which can be relieved by restricting the patient's fluid diet or by the use of the breast pump. Cracked nipples and resulting mastitis are more or less common and these it is a nurse's duty to avoid. Nipples will sometimes crack in spite of all that can be done to prevent, but if they are kept scrupulously clean there should be no infection of the gland. A cracked nipple should be treated as an open wound—a sterile dressing should not only be put on, but kept on when the baby is not nursing, and then it is often advisable to use a sterilized nipple shield. The nurse should remember that an infected breast means not only much suffering to the mother and may deprive the baby of a portion of its nourishment with unfavorable results, but may also lead to cancer in the mother's later life.

About the second day the patient, if a multipara, will often complain of uterine pains, especially upon nursing the baby. Little can be done upon the part of the nurse to relieve these "after-pains" or uterine contractions. The doctor may order a sedative if they are too persistent.

Careful record should be made of anything the patient complains of. If ever such symptoms as headache accompanied by vertigo and dimness of vision be complained of, especially if accompanied by sharp pain, the nurse must be on the lookout for hemorrhage.